



Medical Release Form

Participant Name: _____ Birthdate: _____

I, _____ authorize my physician to release my personal health information to Waterford Place Cancer Resource Center for the purpose of participation in the movement and yoga programs, massage therapy, oncology facials, craniofacial therapy and/or acupuncture.

Participant Signature: _____ Date: _____

To Be Completed by Physician

___ / ___ / ___ Date of diagnosis	___ Patient has completed treatment.
___ / ___ / ___ Date of treatment completion	___ Patient is receiving supportive or palliative care only.
	___ Patient is in or will be in active treatment

**My patient has permission to participate in the following Waterford Place Cancer Resource Center programs:
(Please check all that apply)**

- ___ Movement Programs (Including Group Exercise and Yoga)
- ___ Complementary Therapies (Including Massage, Facials, Vibrational Sound and Reflexology)
- ___ Acupuncture

Please list any specific restrictions:

Physician Name (print): _____

Physician Signature: _____ Date: _____

Medical Office Name / Affiliation: _____

Medical Office Phone Number: _____

PLEASE FAX COPY TO WATERFORD PLACE CANCER RESOURCE CENTER AT 630.800.1768